MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Pharmacy

September 2005 • Bulletin 614

Contents

2005 CPT-4/HCPCS Updates: Implementation November 1, 2005

The 2005 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2005. Specific policy changes are highlighted below. Updated manual replacement pages reflecting the policy changes will be published in a future *Medi-Cal Update.*

DURABLE MEDICAL EQUIPMENT
Deleted and Replacement HCPCS Codes
The following are deleted HCPCS DME codes and their 2005 replacement codes. The policy of the deleted code(s) applies to the replacement code(s).

Deleted Code(s)	Replacement Code(s)
K0627	E0849
K0059 – K0061	E2205
K0081	E2206
E1012	E2292
E1013	E2294
K0650 – K0666	E2601 – E2617, respectively
K0668	E2619

Billing and Reimbursement Restrictions for Select DME HCPCS Codes
New HCPCS code A7045 (exhalation port for positive airway device) is a supply for another DME item and may only be purchased as a replacement for patient-owned equipment. Code A7045 requires a *Treatment Authorization Request* (TAR) and must be billed with modifier -NU (new equipment [purchase]). Reimbursement is limited to one in a 12-month period.

Code E0637 (patient lift, combination sit to stand system, any size, with seat lift, with or without wheels) must now be billed "By Report."

Code E0849 (traction equipment, cervical, free-standing stand/frame) requires prior authorization and is taxable.

Codes E8000 – E8002 (gait trainers) require prior authorization and are reimbursable only for recipients 65 years of age and younger.

Billing and Reimbursement Restrictions for Select Wheelchair and Wheelchair Accessories Codes
Codes E1229, E1239, E2291 – E2294, E2609 – E2610 and E2617 – E2618 require prior authorization.

Codes E2205 and E2206 are not separately reimbursable with codes E1161, E1229, E1231 – E1238, K0001 – K0007 and K0009 when billed during the same month of service.

Code E2368 is not separately reimbursable with codes E1239, K0010 – K0012 and K0014 when billed for the same month of service.

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

Purchase Frequency Restrictions for Select DME Codes
The following DME HCPCS codes have purchase restrictions as noted:

- Codes E2291 – E2294 and E2601 – E2621 are limited to one in a 12-month period.
- Codes E2205 and E2206 are limited to two in a 12-month period.
- Codes E0849, E1039, E1229, E1239, E2368 – E2370 and E8000 – E8002 are limited to one in three years.

Benefits for CCS Clients
The following new DME HCPCS codes are benefits for California Children's Services (CCS) clients only:

- E0463 and E0464 (ventilator)
- E0639 (movable patient lift)
- E0640 (fixed patient lift)

These codes may be reimbursed for Medi-Cal recipients (21 years of age or older) only with an approved TAR.

Reimbursement Restrictions
Ventilator codes E0463 and E0464 may only be rented (bill with modifier -RR [rental]).

Patient lift codes E0639 and E0640 are taxable. Purchase reimbursement is limited to one in three years.

Special Power Wheelchair Interfaces
New DME modifier -KC (replacement of special power wheelchair interface) is activated for use with HCPCS codes E2320 – E2322 and E2327 (special interface for power wheelchair). Claims for these codes must now be billed "By Report" with modifier -NU or -RR at the time the wheelchair is initially purchased or rented. Reimbursement will be the lesser of the amount billed or the maximum allowable for modifier -NU or -RR, as appropriate. Subsequent claims for the replacement of these special interfaces must be billed with modifiers -RP/-NU/-KC or -RR/-KC in that specific order. Reimbursement will be the lesser of the amount billed or the maximum allowable for modifier -KC. Following are the modifier-specific reimbursement rates for these codes:

HCPCS Code	Rental Rates		Purchase Rates	
	-RR	-RR/-KC	-NU	-RP/-NU/-KC
E2320	$102.59	$139.07	$1,025.90	$1,390.58
E2321	$158.92	$223.10	$1,589.10	$2,231.00
E2322	$141.03	$236.26	$1,410.36	$2,362.59
E2327	$261.24	$342.08	$2,612.38	$3,420.77

Reimbursement Adjustments for Select DME Codes
Due to recent adjustments to the Medicare rates for HCPCS codes E0260, E0277, E0431, E0434, E0439, E0570, E1010, E1390, E1391, E2320 – E2324, E2326 – E2330, E2340, E2341 – E2343 and K0001, the Medi-Cal reimbursement rates for these codes have been revised.

ORTHOTICS AND PROSTHETICS
Deleted and Replacement HCPCS Codes
The following are deleted HCPCS prosthetics codes and their 2005 replacement codes. The policy of the deleted code applies to the replacement code.

Deleted Codes	Replacement Code
L5674, L5675	L5685

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

Reimbursement Restrictions for New Orthotic and Prosthetic Codes
The following new HCPCS codes have Medi-Cal policy and/or frequency restrictions as noted:

- Code L4002 is limited to 16 per year.
- Codes L1932, L2005 and L5856 – L5857 are limited to one in three years.
- Codes L2232, L5685, L6694 – L6698 and L7181 are limited to two in three years.
- Codes L2005, L2232, L6694 – L6698 and L7181 require prior authorization.
- Codes L1932, L2232, L4002 and L5685 are reimbursable to podiatrists.

Reimbursement Adjustments for Orthotic Procedures
The maximum reimbursement rates for orthotic HCPCS codes K0646 and K0648 have been revised.

Part B Pharmacy Crossover Claims

Beginning October 24, 2005 Medi-Cal will accept Medicare Part B Pharmacy crossover claims for drugs in the HIPAA-mandated NCPDP 1.1 batch format. As a result, retail pharmacy providers or submitters who are billing Medicare using the NCPDP format will be able to stop billing the Medi-Cal portion of their crossover claims via the *HCFA 1500* paper claim form using HCPCS codes. These claims should cross over automatically from CIGNA Medicare. NCPDP claims that do not cross over automatically must be billed to Medi-Cal using the *Pharmacy Claim Form* (30-1) or the *Compound Drug Pharmacy Claim Form* (30-4) in order to accommodate the National Drug Codes (NDCs).

Providers or submitters who have not yet converted to the NCPDP 1.1 format with Medicare must continue billing the Medi-Cal portion of crossover claims that fail to cross over automatically with the *HCFA 1500* paper claim form using HCPCS codes (not NDCs).

For new crossover claim billing instructions and examples, please refer to the Medicare/Medi-Cal *Crossover Claims: Pharmacy Services* section of the Part 2 Pharmacy manual.

For more information, call the Telephone Service Center (TSC) at 1-800-541-5555, select the appropriate language, and press the following option numbers:

- 14 (this option includes Medicare/Medi-Cal crossover claims), then
- 11 (this option is specific to Medicare/Medi-Cal crossover claims)

These changes are reflected on manual replacement pages compound comp 1, 10 and 14 (Part 2), medi cr ph ex 1, 3 thru 5 and 7 thru 17 (Part 2) and pcf30-1 comp 1, 12 and 16 (Part 2).

Labor Charges for Replacement of DME, Supplies and Accessories

HCPCS code E1340 (repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes) is not reimbursable for the replacement of specified:

- Stand-alone items.
- Separately reimbursable accessories or supplies that are rented or purchased to support patient-owned equipment.

Stand-Alone Items
The following procedure codes identify stand-alone DME items:

A4660, A4670, E0100, E0105, E0110, E0112, E0114, E0117, E0188, E0189, E0199, E0210, E0241 – E0246, E0484, E0602, E0710, E0780, E0942, E0944, E0945, S8185, S8265

Separately Reimbursable Accessories or Supplies (Rented or Purchased)
The following procedure codes identify accessories or supplies that are separately reimbursable with the rental or purchase of their associated equipment:

A4230 – A4232, A6550, A6551, E0352, E2360 – E2365, K0601 – K0605

Retroactive to dates of service on or after November 1, 2004, claims for the replacement of the HCPCS codes listed above will **not** require a statement that the item replaced is for patient-owned equipment in the *Reserved For Local Use* field (Box 19). EDS will automatically reprocess claims for codes previously denied for lack of this statement.

This information is reflected on manual replacement page dura 10 (Part 2).

CPT-4 Procedure Codes and Modifiers Billing Reminder

Providers are reminded that they must select the appropriate CPT-4 code and modifier when billing. The CPT-4 code descriptor must match the procedure performed.

This information is reflected on manual replacement page hcfa comp 16 (Part 2).

Provider Orientation and Update Sessions

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The next orientation session is scheduled for October 20, 2005.

Group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please see **Family PACT**, *page 5*

Family PACT *(continued)*

Please note the upcoming Provider Orientation and Update Session below.

October 20, 2005
The Westin Horton Plaza San Diego
910 Broadway Circle
San Diego, CA 92101
For directions, call
(619) 239-2200

Registration
Call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session listed in this article. Providers must supply the following:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

Check-In
Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present their:

- Medi-Cal provider number
- Medical license number
- Photo identification

Note: Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Certificate of Attendance
Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers will not receive a certificate.

Contact Information
For more information regarding the Family PACT Program, please call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

Primary Care Clinics May Apply for PE Participation

As a result of AB 2307 (Chapter 1, Statutes of 2004 [effective July 1, 2005]), Primary Care Clinics (PCCs) may apply for participation in the Presumptive Eligibility (PE) program for pregnant women while waiting to be determined as a Medi-Cal provider. To accommodate these providers, Part 1 of the *Qualified Provider Application for Presumptive Eligibility Participation/Presumptive Eligibility Qualified Provider Responsibilities and Agreement* form (MC 311, revised 7/05) now includes a checkbox choice that allows PCCs with no Medi-Cal number to apply for PE participation. The updated MC 311 is available on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking the "Forms" link. For general information about the PE program, see the Medi-Cal Web site and click "Presumptive Eligibility" under the "Specialty Programs" heading.

Inpatient Provider Cut-off Date for Proprietary and Non-HIPAA Standard Electronic Claims Formats: December 1, 2005

In accordance with efforts to comply with the federally mandated Health Insurance Portability and Accountability Act (HIPAA), Medi-Cal has established a plan to discontinue acceptance of proprietary and non-HIPAA standard electronic formats for electronic claims transactions. The first provider community to be affected is the Inpatient provider community.

Beginning **December 1, 2005**, proprietary and non-HIPAA standard electronic claim formats submitted by Inpatient providers will no longer be accepted.

Providers may call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

Cut-off dates for non-HIPAA standard claim formats for all other provider communities will be announced in upcoming *Medi-Cal Updates*.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	cal child bil 1/2 * compound comp 1/2, 9/10 and 13/14 dura 9/10 forms reo ph 1/2 * hcfa comp 13/14 *, 15/16
Remove:	medi cr ph ex 1 thru 9
Insert:	medi cr ph ex 1 thru 17 *(new)*
Remove and replace:	pcf30-1 comp 1/2, 11/12 and 15/16
Remove and replace after the *Presumptive Eligibility* section:	*Qualified Provider Application for Presumptive Eligibility Participation/-Presumptive Eligibility Qualified Provider Responsibilities and Agreement* form

* Pages updated due to ongoing provider manual revisions.